DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

0 3 — 0 1 5	Indiana
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE Sept. 2, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
1902(a)(13)(A) & 1923 of Soc Sec ACt	a. FFY 2003 $ 0 b. FFY 2004 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	**9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:**
Attachment 4.19-A, pgs 1H and 1H.1 Attachment 4.19-A, pages 6.1, 7, 8, & 8.1. Attachment 4.19-B, pgs 2.1 & 2.1(a)	Attachment 4.19-A, pg 1H Attachment 4.19-A, pgs 7 & 8 Attachment 4.19-B, page 2.1

10. SUBJECT OF AMENDMENT:
1. Clarification of DSH payment methodology to a hospital not defined as a historical DSH.
2. Amends the methodology used to calculate safety net hospital payments.

ZQS 7/2/04

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: Melanie Bella	16. RETURN TO: Melanie Bella, Assistant Secretary Office of Medicaid Policy & Planning 402 W Washington, Rm W 382 Indianapolis, IN 46204 ATTN: T Brunner, State Plan Coordinator
13. TYPED NAME: Melanie Bella	
14. TITLE: Asst Secretary, OMPP	
15. DATE SUBMITTED: 8/27/03	

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17. DATE RECEIVED:	18. DATE APPROVED: 08/10/2004
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 09/02/2003	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE: DCM

23. REMARKS:

RECEIVED
AUG 29 2003
DMCH - IL/IN/OH

minimum of sixty (60) Indiana Medicaid inpatient days annually. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for this reimbursement.

To be considered for a separate base amount for children's hospitals, out-of-state children's hospitals must be located in a city listed in 405 IAC 5-5-2(a)(3) through 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) Indiana Medicaid inpatient days annually. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for a separate base amount.

MEDICAID INPATIENT PAYMENTS FOR SAFETY-NET HOSPITALS

"Safety-net hospital," for purposes of this section, means an acute care hospital, licensed under IC 16-21, the Indiana hospital licensure statute, and qualified under Section II.E. of this plan as a disproportionate share hospital.

(A) For the state fiscal years ending on or after June 30, 2000*, safety-net hospitals with more than 150 interns and residents, located in a city with a population of over 600,000, and safety-net hospitals which are the sole disproportionate hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less than seven hundred thousand (700,000), which hospitals are also historical disproportionate share hospitals, shall receive reimbursement, subject to the terms of subsection (B) of this section, in an amount calculated by the office from the hospital's cost report filed with the office for the hospital's fiscal period ending during the state fiscal year, equal to the difference between:

(1) the amount of Medicaid payments to the hospital, excluding payments under Section III of this Plan, for Medicaid inpatient services provided by the hospital during the hospital's fiscal year, and

(2) an amount equal to the lesser of the following:

(A) The hospital's customary charges for the services described in subdivision (1).

(B) A reasonable estimate by the office of the amount that would be paid for the services described in subdivision (1) under Medicare payment principles.

The office may also make payments to all other safety-net hospitals in the manner provided in subsection (A) of this section, subject to the provisions of subsection (B) of this section.

(B) If the amount available to pay the inpatient safety-net amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

(C) (1) For the Eligibility Period** beginning July 1, 2001, inpatient safety-net hospitals, which meet both the above definition of "safety-net hospital" and the office's Medicaid safety-net criteria as described in A. above (the "office's Medicaid inpatient safety-net criteria"), limited to those hospitals defined as historical disproportionate share providers under Attachment 4.19A, Section II(F) of this plan and those hospitals not defined as historical disproportionate share providers but meeting the office's Medicaid inpatient safety-net criteria for the Eligibility Period ending on June 30, 2001, will receive inpatient safety-net payments equal to 100% of the amount determined in A. and B. above (the "inpatient safety-net amount"). For later Eligibility Periods, hospitals receiving payment adjustments pursuant to this subsection (1) will be subject to (2), (3), (4) and (5) below, as applicable.

(2) For the Eligibility Periods beginning after June 30, 2001, an inpatient safety-net hospital, whether a historical disproportionate share provider or a hospital which is not a historical disproportionate share provider, receiving a Medicaid inpatient safety-net payment adjustment in the amount of 100% of the inpatient safety-net amount, will continue to receive Medicaid inpatient safety-net payment adjustments in the amount of 100% of the inpatient safety-net amount for subsequent Eligibility Periods in which it meets the office's Medicaid inpatient safety-net criteria, unless the hospital has a lapse in meeting the office's Medicaid inpatient safety-net criteria for an Eligibility Period. A hospital that has a lapse in meeting the office's Medicaid inpatient safety-net criteria for an Eligibility Period shall be subject to (3),(4), and (5) below, as applicable, for later Eligibility Periods.

(3) For the Eligibility Periods beginning after June 30, 2001, if an inpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers, has a lapse in meeting the office's Medicaid inpatient safety-net criteria for any Eligibility Period, the hospital will receive Medicaid inpatient safety-net payment adjustments equal to 0% of its hospital-specific limit for that Eligibility Period. However, upon a later Eligibility Determination† by the office, if the hospital is able to meet the office's Medicaid inpatient safety-net criteria for the Eligibility Period for which the later Eligibility Determination applies, the hospital's Medicaid inpatient safety-net payment adjustment will be calculated as set forth in (2), (4) or (5) of this Section C., as applicable.

(4) Except as set forth in (1) above, for Eligibility Periods beginning after June 30, 2001, inpatient safety-net hospitals, including hospitals defined as historical disproportionate share providers and hospitals which are not defined as historical disproportionate share providers,

(a) licensed under IC 16-21,
(b) meeting the office's Medicaid inpatient safety-net criteria for the current Eligibility Period, and
(c) which did not meet the office's Medicaid inpatient safety-net criteria for the prior Eligibility Period,

will receive Medicaid inpatient safety-net payment adjustments equal to 33 1/3% of their inpatient safety-net amount.

(5) Except as set forth in (2) above, after the Eligibility Period beginning on July 1, 2001, each time the office makes an Eligibility Determination, an inpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers,

(a) meeting the office's Medicaid inpatient safety-net criteria for two consecutive Eligibility Periods will receive a Medicaid inpatient safety-net payment adjustment equal to 66 2/3% of its hospital-specific limit; or
(b) meeting the office's Medicaid inpatient safety-net criteria for three (or more) consecutive Eligibility Periods will receive a Medicaid inpatient safety-net payment adjustment equal to 100% of its hospital-specific limit.

(6) If the amount available to pay the inpatient safety-net amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

*This new payment methodology will apply for Medicaid services on or after April 1, 2000, but will be calculated as set forth in this section. For the state fiscal year ending on June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount not to exceed one-fourth of the amount calculated under the formula described in this section. For state fiscal years ending after June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount up to one hundred percent (100%) of the amount calculated under the formula described in this section.
** The term "Eligibility Period" is defined at Attachment 4.19 A, Section II(P) of this plan.
† The term "Eligibility Determination" is defined at Attachment 4.19A, Section II(O) of this plan.

(O) "Eligibility Determination" means the office's targeted limited scope desk review of survey data, cost and claims reports, and documentation in order to determine (1) the criteria for qualification as a disproportionate share hospital under Section II(E); and (2) hospitals which satisfy that criteria.

(P)"Eligibility Period" means the state fiscal year(s) for which an Eligibility Determination applies and which ends immediately prior to the commencement of the state fiscal year for which the office next makes an Eligibility Determination. The duration of an Eligibility Period shall be at least two SFYs, but no more than four SFYs, in length.

Disproportionate share payments described in this section shall be made on an interim basis throughout the year as determined by OMPP.

B. DSH Payments to Acute Care Hospitals Licensed Under IC 16-21

1. For the state fiscal years ending after June 30, 2000, the following payment methodology will be utilized for the distribution of payments to acute care hospitals licensed under IC 16-21:

   (1) The office will distribute disproportionate share payments to all qualifying acute care hospitals, in an aggregate sum which does not exceed the limits imposed by federal law and regulation, including the statewide allocation limits for disproportionate share payments imposed by 42 USC 1396r-4(f).

   (2) Each qualifying hospital's "hospital specific limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid to the hospital under the non-DSH payment provisions of the State Plan.

   (3) The hospital-specific limit for each hospital shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a hospital to determine the hospital's hospital-specific limit.

2. (a) For the Eligibility Period beginning July 1, 2001, hospitals meeting the office's Medicaid disproportionate share provider criteria as described in Attachment 4.19A, Section II(E) of this Plan (the "office's Medicaid DSH criteria"), limited to those hospitals defined as historical disproportionate share providers under Attachment 4.19A, Section II(F) of this plan and those hospitals not defined as historical disproportionate share providers but meeting the office's Medicaid DSH criteria for the Eligibility Period ending on June 30, 2001, will receive disproportionate share payments equal to 100% of their individual hospital-specific limit. For later Eligibility Periods, hospitals receiving payment pursuant to this subsection (a) will be subject to (b), (c), (d) and (e) below, as applicable.

(b) For the Eligibility Periods beginning after June 30, 2001, a hospital, whether a historic disproportionate share provider or a hospital which is not a historical disproportionate share provider, receiving a Medicaid disproportionate share payment in the amount of 100% of its hospital-specific limit will continue to receive Medicaid disproportionate share payments in the amount of 100% of its hospital-specific limit for subsequent Eligibility Periods in which it meets the office's Medicaid DSH criteria unless the hospital has a lapse in meeting the office's Medicaid DSH criteria for an Eligibility Period. A hospital that has a lapse in meeting the office's Medicaid DSH criteria for an Eligibility Period shall be subject to (c), (d), and (e) below, as applicable, for later Eligibility Periods.

(c) For the Eligibility Periods beginning after June 30, 2001, if a hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers, has a lapse in meeting the office's Medicaid DSH criteria for any Eligibility Period, the hospital will receive Medicaid disproportionate share payment adjustments equal to 0% of its hospital-specific limit for that Eligibility Period. However, upon a later Eligibility Determination by the office, if the hospital is able to meet the office's Medicaid DSH criteria for the Eligibility Period for which the later Eligibility Determination applies, the hospital's Medicaid disproportionate share payment will be calculated as set forth in (b), (d) or (e) of this section 2., as applicable.

(d) Except as set forth in (a) above, for Eligibility Periods beginning after June 30, 2001, hospitals, including hospitals defined as historical disproportionate share providers and hospitals which are not defined as historical disproportionate share providers,

(i) licensed under IC 16-21,

(ii) meeting the office's Medicaid DSH criteria for the current Eligibility Period, and

(iii) which did not meet the office's Medicaid DSH criteria for the prior Eligibility Period,

will receive disproportionate share payments equal to 33 1/3% of their individual hospital-specific limit.

(e) Except as set forth in (b) above, after the Eligibility Period beginning on July 1, 2001, each time the office makes an Eligibility Determination, a hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers,

(i) meeting the office's Medicaid DSH criteria for two consecutive Eligibility Periods will receive a disproportionate share payment equal to 66 2/3% of its hospital-specific limit; or

(ii) meeting the office's Medicaid DSH criteria for three (or more) consecutive Eligibility Periods will receive a disproportionate share payment equal to 100% of its hospital-specific limit.

(f) Except for payments to Non-State Government-Owned or Operated Hospitals, as defined on Attachment 4.19A, Page 17 of this plan, if the amount available to pay the disproportionate share amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

The OMPP may, however, adjust the disproportionate share payment specified above as provided for in 42 CFR 447.297(d)(3), allowing the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. Each eligible hospital may receive an additional disproportionate share payment adjustment, if:

(1) additional funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b (w)(6)(A) and 42 CFR §433.51; and

(2) the total disproportionate share payments to each individual hospital, and all qualifying hospitals in the aggregate, do not exceed the limits provided by federal law and regulation.

The office may also, before the end of a state fiscal year, make a partial payment to one or more qualifying hospitals, if:

(1) sufficient funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b (w)(6)(A) and 42 CFR §433.51;

(2) the partial disproportionate share payment to each hospital does not exceed the limits provided by federal law and regulations; and

(3) no hospital qualifying for a disproportionate share payment for the same state fiscal year for which a partial payment is made will receive a net disproportionate share payment for that state fiscal year in an amount less than the amount the hospital would have received if no partial payment had been made before the end of the fiscal year.

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MEDICAID OUTPATIENT PAYMENTS FOR SAFETY-NET HOSPITALS

"Safety-net hospital", for purposes of this section, means an acute care hospital, licensed under IC 16-21, the Indiana hospital licensure statute, and qualified under Section II.E. of this plan as a disproportionate share hospital.

A. For the state fiscal years ending on or after June 30, 2000, safety-net hospitals with more than 150 interns and residents, located in a city with a population of over 600,000, and safety-net hospitals which are the sole disproportionate share hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less that seven hundred thousand (700,000), which hospitals are also historical disproportionate share hospitals, shall receive reimbursement, subject to the terms of subsection (B) of this section, in an amount calculated by the office from the hospital's cost report filed with the office for the hospital's fiscal period ending during the state fiscal year, equal to the difference between:

(1) the amount of Medicaid payments to the hospital, excluding payments under Section III of this Plan, for Medicaid outpatient services provided by the hospital during the hospital's fiscal year, and

(2) an amount equal to the lesser of the following:

(A) The hospital's customary charges for the services described in subdivision (1).

(B) A reasonable estimate by the office of the amount that would be paid for the services described in subdivision (1) under Medicare payment principles.

The office may also make payments to all other safety-net hospitals in the manner provided in subsection A. of this section, subject to the provisions of subsection B. of this section.

B. If the amount available to pay the outpatient safety-net amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

C. (1) For the Eligibility Period** beginning July 1, 2001, outpatient safety-net hospitals, meeting the office's Medicaid safety-net criteria as described in A. above (the "office's Medicaid outpatient safety-net criteria"), limited to those hospitals defined as historical disproportionate share providers under Attachment 4.19A, Section II(F) of this plan and those hospitals not defined as historical disproportionate share providers but meeting the office's Medicaid outpatient safety-net criteria for the Eligibility Period ending on June 30, 2001, will receive outpatient safety-net payments equal to 100% of the amount determined in A. and B. above (the "outpatient safety-net amount"). For later Eligibility Periods, hospitals receiving payment adjustments pursuant to this subsection (1) will be subject to (2), (3), (4) and (5) below, as applicable .

(2) For the Eligibility Periods beginning after June 30, 2001, an outpatient safety-net hospital, whether a historical disproportionate share provider or a hospital which is not a historical disproportionate share provider, receiving a Medicaid outpatient safety-net payment adjustment in the amount of 100% of the outpatient safety-net amount, will continue to receive Medicaid outpatient safety-net payment adjustments in the amount of 100% of the outpatient safety-net amount for subsequent Eligibility Periods in which it meets the office's Medicaid outpatient safety-net criteria, unless the hospital has a lapse in meeting the office's Medicaid outpatient safety-net criteria for an Eligibility Period. A hospital that has a lapse in meeting the office's Medicaid outpatient safety-net criteria for an Eligibility Period shall be subject to (3),(4), and (5) below, as applicable, for later Eligibility Periods.

(3) For the Eligibility Periods beginning after June 30, 2001, if an outpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers, has a lapse in meeting the office's Medicaid outpatient safety-net criteria for any Eligibility Period, the hospital will receive Medicaid outpatient safety-net payment adjustments equal to 0% of its hospital-specific limit for that Eligibility Period. However, upon a later Eligibility Determination† by the office, if the hospital is able to meet the office's Medicaid outpatient safety-net criteria for the Eligibility Period for which the later Eligibility Determination applies, the hospital's Medicaid outpatient safety-net payment adjustment will be calculated as set forth in (2), (4) or (5) of this Section C., as applicable.

(4) Except as set forth in (1) above, for Eligibility Periods beginning after June 30, 2001, outpatient safety-net hospitals, including hospitals defined as historical disproportionate share providers and hospitals which are not defined as historical disproportionate share providers,

(a) licensed under IC 16-21,

(b) meeting the office's Medicaid outpatient safety-net criteria for the current Eligibility Period, and

(c) which did not meet the office's Medicaid outpatient safety-net criteria for the prior Eligibility Period,

will receive Medicaid outpatient safety-net payment adjustments equal to 33 1/3% of their outpatient safety-net amount.

(5) Except as set forth in (2) above, after the Eligibility Period beginning on July 1, 2001, each time the office makes an Eligibility Determination, an outpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers,

(a) meeting the office's Medicaid outpatient safety-net criteria for two consecutive Eligibility Periods will receive a Medicaid outpatient safety-net payment adjustment equal to 66 2/3% of its hospital-specific limit; or

(b) meeting the office's Medicaid outpatient safety-net criteria for three (or more) consecutive Eligibility Periods will receive a Medicaid outpatient safety-net payment adjustment equal to 100% of its hospital-specific limit.

(6 If the amount available to pay the outpatient safety-net amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

This new payment methodology will only apply for Medicaid services on or after April 1, 2000, but will be calculated as set forth in this section. For the state fiscal year ending on June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount not to exceed one-fourth of the amount calculated under the formula described in this section. For state fiscal years ending after June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount up to one hundred percent (100%) of the amount calculated under the formula described in this section.

** The term "Eligibility Period" is defined at Attachment 4.19 A, Section II(P) of this plan.
† The term "Eligibility Determination" is defined at Attachment 4.19A, Section II(O) of this plan.